DEPARTMENT OF CORRECTIONS
POLICIES AND PROCEDURES

Policy No.: DOC 4.5.34	Subject: **OFFENDER DEATH**
Chapter 4: FACILITY/PROGRAM SERVICES	Page 1 of 3
Section 5: Health Care	Revision Date:
Signature: /s/ by Director Rick Day 1/5/98	Effective Date: May 1, 1998

I. POLICY:

It is the policy of the Department of Corrections to establish reporting procedures regarding notification of local authorities in the event of an offender's death at Department facilities and programs.

II. AUTHORITY:

53-1-203, MCA. Powers and Duties of the Department of Corrections

National Commission on Correctional Health Care:

- Standards for Health Services in Prison, 1997
- Standards for Health Services in Juvenile Detention and Confinement Facilities, 1995

46-4-122, MCA. Human Deaths Requiring Inquiry by Coroner.

III. DEFINITIONS:

Death means when an individual has sustained either irreversible cessation of circulatory and respiratory functions or irreversible cessation of all functions of the entire brain, including the brain stem. Death can be pronounced by any individual but can only be certified by a physician or coroner. (50-22-101, MCA)

Mortality Review means a process of evaluating the cause of death and the events preceding and following the event to ascertain if any area could be improved.

Sentinel Event means a sudden unexpected event in the course of overall care. This may be a system issue or unexpected direct complication. The death of an inmate always becomes a sentinel event.

IV. PROCEDURES:

A. Notification

1. In the event of an offender's death, the nurse or staff in charge must notify the Command Post, local facility manager/nursing supervisor, the responsible physician, and the Warden/Superintendent/Program Manager or designee.

2. In the event of an offender's death, the Warden/Superintendent/Program Manager or designee will notify the Medical Examiner/Coroner, Department Investigator, and appropriate law enforcement officials. A post mortem examination will be requested by the Warden/Superintendent/Program Manager or designee.

3. The Department Director will be notified immediately by phone of all offender deaths.

B. Progress Notes and Incident Reports

Progress notes shall be made by the nurse on the case as soon as possible but no later than the end of the shift, citing witnessed facts concerning:

1. time of expiration,
2. nature of death,
3. circumstances surrounding nature of death at that time,
4. treatment rendered (if any),
5. persons notified of death, and
6. whether an autopsy was requested.

Incident reports shall be made by all staff witnessing the death as soon as possible but no later than the end of the shift.

C. Release of Information

Department personnel are not to release information concerning the death to outside media, e.g., newspapers, reporters, etc. All such questions are to be referred to the Warden/ Superintendent/Program Manager or the Public Information Officer.

D. Report of Offender Death and Health Record

Within 24 hours, the local facility manager/nursing supervisor will complete and forward a report of offender death to the Department Director, Professional Services Division Administrator, and to the Investigation Unit with a copy of the offender's health record. The original health record is to be kept in a locked cabinet on site. All entries will be completed in the health record. All pages on the health record will be numbered.

E. Continuous Quality Improvement Review

The Health Services Manager will coordinate the mortality review/sentinel event within 30 working days of the offender's death.

In the event a continuous quality improvement program is not fully implemented at the very least, a mortality review will be conducted. The Health Services Manager will notify all necessary disciplines involved, including medical (physicians, nurses, etc.), mental health, and custody staff. This multi-disciplinary effort will determine if there was a pattern of symptoms which might have resulted in earlier diagnosis and intervention. Additionally, events immediately surrounding the death will be reviewed in order to determine if appropriate interventions were undertaken.

F. Review by Medical Examiner/Coroner

All offender deaths and subsequent reports will be reviewed by the Medical Examiner/ Coroner.

V. CLOSING:

Questions concerning this policy shall be directed to the Department Health Services Manager.